Office of Patient Protection
Frequently Asked Questions Regarding External Review

What is the patient's rights law for managed care?

Chapter 141 of the Acts of 2000 was signed into law by former Governor Cellucci on July 21, 2000. This law created the Office of Patient Protection within the Department of Public Health, and added chapter 176O, Health Insurance Consumer Protections, to the Massachusetts General Laws. Under chapter 176O, which took effect on January 1, 2001, Massachusetts consumers and other individuals who receive health coverage from a Massachusetts insurer or HMO are entitled to new protections covering internal grievances, medical necessity guidelines, continuity of care and independent external reviews.

To whom does the law apply?

The law applies to fully insured health plans issued in Massachusetts. The law does not apply to self-funded employer health plans, Medicare, Medicaid or federal employee plans. If you have questions about whether the law applies to your health plan, call the Office of Patient Protection at 1-800-436-7757.

Internal Grievances and Appeals

My plan offers several levels of internal grievance. How much time can it take to decide my case?

Unless you agree to extend the time frame, Massachusetts law requires your health plan to provide you with a written resolution of your grievance within 30 business days, regardless of the number of levels of review. (Plans subject to regulation by the federal Department of Labor may be required to act more quickly in certain circumstances. Please call 1-866-444-3272 or visit their website at www.dol.gov/ebsa for further information about federal requirements.)

Can my health plan delay the internal grievance process?

Not without your permission. Unless you have agreed in writing to an extension of the time frame, your health plan must make a determination on your internal grievance within 30 business days of receipt of the grievance. If medical records are requested, the 30-day period begins on the date you submit a signed release form to the plan.

What if my health plan fails to reach a timely decision on my internal grievance?

If the health plan does not issue a written resolution within 30 business days, and you have not agreed to an extension of time, the adverse determination is considered reversed and the health care services must be provided. No external review is necessary.

Are there any circumstances under which the health plan has to act more quickly?

The law requires the health plan to issue a decision regarding inpatient care prior to the patient's discharge from the hospital. Health plans are required to act within 48 hours when a physician certifies that there is substantial risk of immediate harm to a patient, or within five days for terminally ill patients. If you think you may be entitled to an expedited review, call the Office of Patient Protection at 1 800-436-7757 to discuss your case.

As noted above, federal requirements may also require a plan to act more quickly in some circumstances; however, the Office of Patient Protection enforces only state law.

I called my health plan with a complaint, but I was told to put it in writing. Do I have to start over and mail in my appeal?

No. The law requires health plans to accept grievances by phone, by mail, in person or electronically (by fax or e-mail). In addition, if you submit your grievance orally, the health plan is required to send you a written summary of your complaint within 48 hours. If you think your health plan is not complying with the law, call the Office of Patient Protection at 1-800-436-7757.

Can my health plan cut off my benefits while it is considering my appeal?

The law requires that the health plan continue to cover treatment during the internal appeals process if the treatment was initially authorized by the health plan and was not terminated because of a specific time or episode-related exclusion in the contract. If you think you may be eligible for continuing coverage during the internal appeal, call the Office of Patient Protection at 1-800-436-7757 to discuss your case. If eligible, the coverage must continue at the health plan's expense until the health plan issues its final decision.

External Review

What is an external review?

External review provides an independent review process for individuals covered by a fully insured Massachusetts health plan who have been denied benefits for reasons of medical necessity. In order to be eligible for external review, the service or supply being requested must be a covered benefit in the particular health plan contract -- that is, it cannot be explicitly excluded from the health plan. Medical professionals who are not affiliated with your health plan review your case and issue a determination. The results of external reviews are binding on your health plan.

How is medical necessity defined?

Medical necessity means health care services that are consistent with the generally accepted principles of professional medical practice as determined by whether the service:

1) Is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual;
2) Is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
3) For services and interventions not in widespread use, is based on scientific evidence.

What is meant by "explicitly excluded?"

Your health insurance evidence of coverage tells you what is covered under your plan. It will also have a section of exclusions. For example, some plans specifically exclude acupuncture; others might exclude coverage for dental procedures. Because these exclusions apply to all treatment, a request for such a noncovered service is not eligible for external review.

Services that are covered under certain circumstances or when certain criteria are met are eligible for external review. For example, a health plan denies a procedure because it considers it to be cosmetic, but the patient's physician states that the procedure addresses a functional deformity. Such a denial would be considered an adverse determination and therefore eligible for external review.

When can I request an external review?

First you must file an internal grievance with your health plan. If the health plan still refuses to cover the requested service, you have 45 days from the date you receive a final adverse determination to file for external review. The application for external review

must be sent to the Office of Patient Protection in the Massachusetts Department of Public Health.

What is a "final adverse determination?"

An adverse determination is a decision by the health plan to deny, reduce, modify or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness. A final adverse determination is an adverse determination made after an insured has exhausted all remedies available through a health plan's formal internal grievance process.

Does an external review cost anything?

The first $25.00 of the cost of the external review must be paid by the insured. The fee may be waived in cases of financial hardship. The remainder of the cost of review is paid by the health plan.

How long does an external review take?

External review agencies have 60 business days to make a determination. The 60-day period begins on the day the external review agency receives the request for external review from the Massachusetts Department of Public Health. The review agency may extend the time period for making a decision 15 additional business days if it needs additional time. However, if a physician certifies that an expedited review is necessary because a delay in providing the requested services would pose a serious and immediate threat to your health, the external review agency must render a decision in five business days.

Who conducts the external review?

The Massachusetts Department of Public Health contracts with three external review agencies: The Center for Health Dispute Resolution (CHDR), and the Island Peer Review Organization (IPRO), both located in New York, and Independent Medical Expert Consulting Services, Inc. dba IMEDECS, located in Pennsylvania. The reviews are conducted by independent experienced physicians or other health care professionals from all over the United States who typically treat the health care conditions under review.

Does my health plan have to abide by the decision?

Yes. By law, external review decisions are binding.

How can I obtain a copy of an external review application?

Your health plan must explain the procedures for requesting an external review and include the external review forms whenever it issues a final adverse determination. You can also request a copy of an external review application from the Office of Patient Protection at 1-800-436-7757 or download the form from its website at http://www.state.ma.us/dph/opp.

Can I participate in the external review?

The external review is a paper review, i.e., the independent physician or other professional reviews the medical records of the case. There is no hearing or other proceeding. If you have information that you want the reviewer to consider, it is important that you provide this information with your request for external review.

Does my health plan have to continue my coverage during the external review?

The law permits an insured to ask the external review agency to order continuation of coverage or treatment where a physician certifies that substantial harm to the patient's health may result if the coverage is not continued. This request must be made by the end of the second business day following the insured's receipt of the final adverse determination. Additionally, the treatment must have been initially authorized by the health plan and not terminated because of a specific time or episode-related exclusion in the contract. If the external reviewer orders continuation, the health plan must continue to pay for the coverage during the external review.

Eligibility

I have health insurance through my employer. Am I eligible for external review?

You are eligible if your plan is fully insured. You are not eligible for this external review process if you are a member of a self-insured plan.

What does "self-insured" mean?

Under a self-insured or self-funded plan, your employer pays the costs for its employees' health care directly instead of paying premiums to buy health insurance. Some self-insured employers hire insurance companies to process the paperwork, so it is not always easy to tell if you are in a self-funded plan. Check with your employer if you are unsure of whether or not your plan is self-insured.

I am covered by Medicare or Medicaid (MassHealth), but have no additional coverage. Am I entitled to external review?

You are not eligible for this external review process for Medicare or Medicaid (MassHealth) denials. However, both plans do provide appeal rights, so please see the numbers at the end of this document to find out whom to call for more information about your rights

What if I have further questions about external review?

Call the Office of Patient Protection at 1-800-436-7757. The office is open from 8:45 a.m. to 5:00 p.m. Monday through Friday. You can also leave a message at any time.

Where can I get a copy of the law and regulations regarding managed care consumer protections?

The law and current regulations can be found on this OPP website. There are also other helpful links you may want to visit, such as the Division of Insurance at www.state.ma.us/doi.
Other Resources

Attorney General's Insurance Hotline 1-888-830-6277
Division of Insurance Consumer Hotline 1-617-521-7777
Division of Medical Assistance (MassHealth/Medicaid) 1-800-841-2900
Federal Office of Employee Benefits Security Administration (Employer self-funded health plans and federal Department of Labor rules) 1-866-444-3272
Executive Office of Elder Affairs 1-800-243-4636
Medicare Hotline 1-800-638-6833